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Z035/039 FRX 6157417051 TOOH HCF 05/02/2018 WED 16:23 PRINTED: 04/19/2018 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES A. BUILDING 01 - MAIN BUILDING IDENTIFICATION NUMBER: AND PLAN OF CORRECTION 04/16/2018 445170 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **500 HICKORY HOLLOW TERRACE** GOOD SAMARITAN HEALTH AND REHAB CENTER ANTIOCH, TN 37013 PROVIDER'S PLAN OF CORRECTION (X8) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LOC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG K 000 K 000 INITIAL COMMENTS A Life Safety Code Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulations Office of Health Care Facilities on 04/16/2018. During this Life Safety Survey, Good Samaritan Health and Rehab Center was found not in substantial compliance with the requirements for participation in Medicare/Medicald with Title 42 CFR Subpart 483.70(a). The Rules of Tennessee Department of Health Board for Licensing Health Care Facilities Chapter 1200-08-06 Standards For Nursing Homes, and National Fire Protection Association (NFPA) 101 Life Safety (2012 Edition). * All penetrations requiring Fire Stop shall be repaired in accordance with a tested and approved Fire Stop System meeting the requirements of the UL (Underwriters Laboratory) assembly to which the Fire Stop is being applied. The system used shall be recorded and documentation shall be maintained for the life of the installation. *Any Engineering Judgments for Fire Stop requires State approval. All damaged, painted, or corroded sprinklers shall be replaced in accordance with NFPA 25, Standards for the Inspection, Testing, and Maintenance of Water-Based Fire Protection

Any deficiency sistement ending with an esterisk (") denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosuble 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days tollowing the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

K 353

FORM CMB-2587(02-99) Previous Versions Obsoleta

Systems (2011 Edition).

SS#D CFR(s): NFPA 101

Sprinkler System - Maintenance and Testing

Sprinklar System - Maintenance and Testing Automatic sprinkler and standpipe systems are

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Event ID: 24XE21

Facility ID: TN1909

TITLE

If continuation sheet Page 1

(XI) DATE



05/02/2018 WED 16:23 FAN 6157417051 TOOH HCF

DEPARTMENT OF HEALTH AND HUMAN SERVICES

2036/039

PRINTED: 04/19/2011 FORM APPROVED

OMB NO. 0938-0391

CENTER	S FOR MEDICAR	E & MEDICAID SERVICES			CIVID MO	
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIFLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING			E SURVEY
		445170	B. WING		04/	16/2018
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HEALTH AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 500 HICKORY HOLLOW TERRACE ANTIOCH, TN 37013			
(X4) ID PREFIX TAG	IGACH DESIGNA	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REPERENCED TO THE APPR DEFICIENCY)	JLD BE	COMPLETION DATE
	with NFPA 25, Startesting, and Maint Protection System maintenance, insp maintained in a seavallable. a) Date sprinkler b) Who provided c) Water system Provide in REMAF any non-required caystem. 9.7.5, 9.7.7, 9.7.8, This REQUIREMENT.	and maintained in accordance ndard for the inspection, aining of Water-based Fire s. Records of system design, ection and testing are cure location and readily system last checked system test supply source RKS information on coverage for partial automatic sprinkler and NFPA 25. ENT is not met as evidenced ations, the facility failed to	K 353	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Pye – Barker conducted on-site visit April 20, 2018, made inspection of the following areas. Room 306 Room 200 - Water Heater Room- Front Lobby Restro Schedule date for repair completion 5/15/18. (See attachment #1).		

The findings include:

Observation of 04/16/2018 between 11:45 AM and 12:18 PM, revealed sprinkler deficiencies in the following locations: a, RM 306 (1 of 2) Painted

b. Water heater room 200 hall painted

c. Public restroom by the front door NFPA 101, 19.3.5.1 (2012 Edition), NFPA 101,9.7.1.1 (2012 Edition), NFPA 13, 26.1 (2010 Edition), NFPA 25, 5.2.1.1.2 (2011 Edition)

The maintenance director was present for the : findings which were later acknowledged by the administrator during the exit conference on 04/10/2018.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;

Vendor, Pye - Barker surveyed the entire building and observed all the sprinkler heads. Those identified in need of repair or replacement will replaced.

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2036/039

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER

(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING (X3) DATE SURVEY

446170

a. WING

04/16/2018

NAME OF PROVIDER OR SUPPLIER

GOOD SAMARITAN HEALTH AND REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE 500 HICKORY HOLLOW TERRACE

ANTIOCH, TN 37013

SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG

PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

COMPLETION DATE

K 353 Continued From page 1

inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, Inspection and testing are maintained in a secure location and readily available.

- a) Date sprinkler system last checked
- b) Who provided system test
- c) Water system supply source

Provide in REMARKS Information on coverage for any non-required or partial automatic sprinkler system.

9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced

Based on observations, the facility failed to maintain the sprinkler system.

The findings include:

Observation of 04/16/2018 between 11:45 AM and 12:18 PM, revealed sprinkler deficiencies in : the following locations:

- a. RM 306 (1 of 2) Painted
- b. Water heater room 200 half painted
- c. Public restroom by the front door NFPA 101, 19,3.5.1 (2012 Edition), NFPA 101,9.7.1.1 (2012 Edition), NFPA 13, 26.1 (2010 Edition), NFPA 25, 5.2.1.1.2 (2011 Edition)

The maintenance director was present for the findings which were later acknowledged by the administrator during the exit conference on 04/16/2018.

K 353

What measure will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; and

The facility maintenance staff will conduct monthly monitoring rounds, or more often if needed to ensure sprinkler heads are free of paint/debris.

Vendor, Pve – Barker will make annual inspections to ensure compliance.

Event ID: 24XE21

Facility ID: TN1909

If continuation sheet Page 2 of

05/02/2018 WED 16:23 FAX 6157417051 TDOR HCF

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PRINTED: 04/19/2016

FORMAPPROVEC OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION

(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING (X3) DATE SURVEY COMPLETED

445170

B. WING

04/16/2018

NAME OF PROVIDER OR SUPPLIER

GOOD SAMARITAN HEALTH AND REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE 500 HICKORY HOLLOW TERRACE ANTIOCH, TN 37013

PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES JEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X6) COMPLETION DATE

K 363 Continued From page 1

inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily

- a) Date sprinkler system last checked
- b) Who provided system test
- c) Water system supply source

Provide in REMARKS Information on coverage for any non-required or partial automatic aprinkler system.

9.7.5. 9.7.7. 9.7.8. and NFPA 25 This REQUIREMENT is not met as evidenced

Based on observations, the facility failed to maintain the sprinkler system.

The findings include:

Observation of 04/16/2018 between 11:45 AM and 12:18 PM, revealed sprinkler deficiencies in the following locations:

- a. RM 306 (1 of 2) Painted
- b. Water heater room 200 hall painted
- c. Public restroom by the front door NFPA 101, 19.3.5.1 (2012 Edition), NFPA 101,9.7.1.1 (2012 Edition), NFPA 13, 28.1 (2010 Edition), NFPA 25, 5.2.1.1.2 (2011 Edition)

The maintenance director was present for the findings which were later acknowledged by the administrator during the exit conference on 04/16/2018.

K 353

How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.

The Physical Plant Manager will Monitor for compliance.

All non-compliance concerns will be referred to the QAPI Committee for review of effectiveness of the interventions implemented.

The members include Administrator, Assistant Administrator, DON, DSD, QA Coordinator, MDS Coordinator, Activity Manager, Dietary Manager, Rehab Manager, Social Services Director, Physical Plant & Maintenance Mgr., Medical Records Manager and RN/CNT.

Monitoring will be conducted daily, weekly, monthly or as ordered by the Medial Director. 05/02/2018 WED 16:24 FAX 6157417051 TDOH HCF

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PRINTED: 04/19/2018

FORM APPROVED OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

PREFIX

DAT

(X1) PROVIDER/SUPPLIER/QUA IDENTIFICATION NUMBER.

A BUILDING 01 - MAIN BUILDING

445170

B. WING

PREFIX

TAG

K 920

K 920

04/16/2018

(X5) COMPLETION

NAME OF PROVIDER OR SUPPLIER

GOOD SAMARITAN HEALTH AND REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE 500 HICKORY HOLLOW TERRACE ANTIOCH, TN 37013

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL

K 920 Continued From page 2 K 920 Electrical Equipment - Power Cords and Extens SS=D CFR(s): NFPA 101

REGULATORY OR LSC IDENTIFYING INFORMATION)

Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed Immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8

(NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by:

Based on observations, the facility failed to use the proper power taps.

Observations on 04/16/2018 between 11:24 AM and 11:44 AM, revealed improper use of power taps in the following locations:

- a. RM 114 (Medical Equipment)
- b. RM 208 (Personal Equipment)
- c. RM 209 (Personal Equipment)
- d. RM 207 (2, one with medical equipment and

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice

The non-compliant power strips were replaced 4/16/18 with UL - 1363 power strips in the following rooms.

Room-114

Room - 208

Room - 209

Room -- 305

Room – 207 (2 strips were replaced)

(SEE ATTACHMENT 2)

FORM CMG-2597(02-99) Previous Versions Obsolete

Event ID: 24XE21

Facility ID: TN1809

If continuation sheet Page 3 o

AND PLAN OF CORRECTION

05/02/2018 WED 16:24 FAX 6157417051 TOOH HCF

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PRINTED: 04/19/2018

FORM APPROVED OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.

(X2) MULTIPLE CONSTRUCTION A. BUILDING Of - MAIN BUILDING

B. WING

K 920

K 920

(X3) DATE SURVEY COMPLETED

04/16/2018

NAME OF PROVIDER OR SUPPLIER

GOOD SAMARITAN HEALTH AND REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE 500 HICKORY HOLLOW TERRACE ANTIOCH, TN 37013

SUMMARY STATEMENT OF DEFICIENCIES (XA) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG

ID PREFIX TAG

445170

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X6) COMPLETION DATE

K 920 Continued From page 2

K 920 Electrical Equipment - Power Cords and Extens SS=D CFR(s): NFPA 101

> Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed

> immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4.

10,2,3,6 (NFPA 99), 10,2,4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced

Based on observations, the facility failed to use the proper power taps.

Observations on 04/16/2018 between 11:24 AM and 11:44 AM, revealed improper use of power taps in the following locations:

- a, RM 114 (Medical Equipment)
- b. RM 208 (Personal Equipment)
- c. RM 209 (Personal Equipment)
- d. RM 207 (2, one with medical equipment and

How will you Identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;

The facility maintenance staff will conduct monthly monitoring, or more often If needed to ensure appropriate power strips are in place.

What measure will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; and

The newly assigned QAPI team will monitor for appropriate power strips during the daily rounds and document the findings on the "IDT Dally Rounds Report Sheet"

FORM CM8-2507(02-99) Previous Versions Obsolete

Event ID: 24XE21

Facility ID: TN1908

If continuation sheet Page 3 of

05/02/2018 WED 16:25 FAX 6157417051 TOOH HCF

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Zi038/039 INTED: 04/19/201

PRINTED: 04/19/2016 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICAR	E & MEDICAID SERVICES		OMB NO. 0938-039			
STATEMENT OF DEFIDIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING 0) - MAIN BUILDING			SURVEY PLETED	
	445170	B. WING			6/2018	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HEALTH		500 HICH	ADDRESS, CITY, STATE, ZIP CODE KORY HOLLOW TERRACE CH, TN 37013			

(X4) ID SUMMARY STATEMENT OF DEFICIENCIES
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

K 920

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATÉ

K 920 Continued From page 3 one with personal equipment)

NFPA 99, 10.2.4 (2012 Edition)

The maintenance director was present for the

The maintenance director was present for the findings which were later acknowledged by the administrator during the exit conference on 04/16/2018.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.

The Physical Plant Manager will Monitor for compliance.

All non-compliance concerns will be referred to the QAPI Committee for review of effectiveness of the interventions implemented.

The members include
Administrator, Assistant
Administrator, DON, DSD,
QA Coordinator, MDS
Coordinator, Activity
Manager, Dietary Manager,
Rehab Manager, Social Services
Director, Physical Plant &
Maintenance Mgr., Medical
Records Manager and RN/CNT.

Monitoring will be conducted daily, weekly, monthly or as ordered by the Medial Director.

FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: 24XE21

Facility ID: TN1909

If continuation sheet Page 4 o